BASIC PLAN
(For Low-Income Children and Working-Age Adults)
BENCHMARK BENEFIT PACKAGE

SECTION 1. GENERAL OVERVIEW

1.A ADMINISTRATIVE AUTHORITIES

As a condition for receipt of Federal funds under Titles XIX and XXI of the Social Security Act, the Idaho Department of Health and Welfare submits the following Basic Benchmark Benefit Package, and hereby agrees to administer the program in accordance with the provisions of Titles XI, XIX and XXI of the Act, and all applicable Federal regulations and other official issuances of the US Department of Health and Human Services.

The Idaho Department of Health and Welfare is the single State agency designated to administer or supervise the administration of the Medicaid program under Titles XIX and XXI of the Social Security Act. (All references to "the Department" mean the Idaho Department of Health and Welfare.)

The health benefits coverage available under the Basic Benchmark Benefit Package provides appropriate coverage for the applicable populations as determined by the Secretary of the US Department of Health and Human Services pursuant to his authority under section 1937 of the Social Security Act. All references to "the Secretary" mean the Secretary of the US Department of Health and Human Services; all references to "the Act" mean the Social Security Act.)

All other provisions of the Basic Benchmark Benefit Package are administered by the Department in accordance with statutory authority granted under Chapter 2 of Title 56, Idaho Code. The Basic Benchmark Benefit Package as described in this State Plan Amendment shall constitute the State Plan for Low-Income Children and Working-Age Adults as set forth in section 56-255, Idaho Code.

1.B POLICY GOALS

The broad policy goal for provision of the Basic Benchmark Benefit Package for Low-Income Children and Working-Age Adults is to achieve and maintain wellness by emphasizing prevention and proactively managing health.

Additional specific goals are:

- To emphasize preventive care and wellness;
- To increase participant ability to make good health choices; and
- To strengthen the employer-based health insurance

system.

1.C **GEOGRAPHIC CLASSIFICATION**

Unless otherwise indicated in the chart below, the benefits in the Basic Benchmark Benefit Package shall be in effect for all geographic and political subdivisions of the State.

Benefit	**Geographic Area**
Transportation Brokerage	DHW Regions 5, 6, and 7
Case Management for Pregnant and Parenting Teens	Adams, Washington, Payette, Gem, Canyon, or Owyhee counties.

1.D SERVICE DELIVERY SYSTEM

Each individual provided the Basic Benchmark Benefit Package is required to enroll in a Primary Care Case Management program, known as "Healthy Connections" as specified pursuant to a waiver program authorized under section 1915(b) of the Social Security Act.

Certain covered individuals with selected chronic diseases may enroll with a Primary Care Case Management (PCCM) provider who receives an enhanced PCCM fee for measured clinical best practices related to chronic disease management. Enhanced PCCM fees are performance-based incentive payments made for individuals with the following chronic conditions:

- Diabetes;
- Asthma;
- Cardiovascular disease; or
- Depression.

Except as otherwise indicated in the chart below, beneficiaries may obtain the services available under the plan from any institution, agency, pharmacy, or practitioner qualified to perform such services and participating under the plan, including an organization, which provides such services or arranges for their availability on a pre-payment basis.

Primary Care Case Management System
Inpatient Hospital Services Outpatient Hospital Services (excluding Emergency Services) Ambulatory Surgical Center Services Physician Services

Other Practitioner Services (excl. Chiropractors and Podiatrists) Laboratory and Radiological (X-Ray) Services Inpatient Psychiatric Services Outpatient Mental Health Services Home Health Care Physical Therapy Respiratory Care Services Prosthetic Devices Medical and Surgical Services furnished by a dentist Rural Health Clinic Services Federally qualified Health Center Services Independent School District Services EPSDT Pregnancy-Related Services
Managed Care Entity/Selective Contracting
Enhanced PCCM for Chronic Conditions Durable Medical Equipment and Supplies Eyeglasses Other Dental Care Transportation Brokerage

SECTION 2. COVERED POPULATIONS

2.A. COVERED INDIVIDUALS

The Basic Benchmark Benefit Package is available to the groups specified in this Section.

The conditions of eligibility that must be met are specified in this State Plan.

The following groups will be offered opt-in alternative coverage under the Basic Benchmark Benefit Package covered under this State plan.

2.A.1 AFDC-Related Individuals

The Basic Benchmark Benefit Package is available for recipients of AFDC. The approved State AFDC plan includes:

- Families with an unemployed parent for the mandatory 6-month period and an optional extension of 6 months.
- Pregnant women with no other eligible children.
- AFDC children age 18 who are full-time students in a

secondary school or in the equivalent level of vocational or technical training.

The following groups were included in the AFDC State plan effective July 16, 1996:

- Pregnant women with no other eligible children.
- AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The Basic Benchmark Benefit Package is available for deemed recipients of AFDC. Deemed recipients of AFDC include:

- Individuals denied a Title IV-A cash payment solely because the amount would be less than $10.
- Effective October 1, 1990, participants in a work supplementation program under Title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.
- Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.
- An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.

The Basic Benchmark Benefit Package is available for families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)

The Basic Benchmark Benefit Package is available for families denied AFDC solely because of income and resources deemed to be available from:

- Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;
- Grandparents;

- Legal guardians; and

- Individual alien sponsors (who are not spouses of the individual or the individual's parent);

The Basic Benchmark Benefit Package is available for families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.

The Basic Benchmark Benefit Package is available for families denied AFDC because the family transferred a resource without receiving adequate compensation.

The Basic Benchmark Benefit Package is available for individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972. This includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan). This also includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

The Basic Benchmark Benefit Package is available for qualified pregnant women and children. A qualified pregnant woman is an individual whose pregnancy has been medically verified who:

- Would be eligible for an AFDC cash payment if the child had been born and was living with her;

- Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents Program; or

- Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

The Basic Benchmark Benefit Package is available for children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

The Basic Benchmark Benefit Package is available for caretaker relatives and pregnant women who would be eligible for AFDC as specified in 42 CFR 435.230, but who do not receive cash assistance.

The Basic Benchmark Benefit Package is available for individuals under age 18 who, except for age and school attendance, would be recipients of AFDC.

The Basic Benchmark Benefit Package is available for an incapacitated parent required to accept remedial medical treatment who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under Title IV-A.

The Basic Benchmark Benefit Package is available for low-income families and children under section 1931 of the Act. Section 402(a)(41) and various provisions at 45 CFR 233.101 (a)(1) and (c)(i)(iii) as in effect prior to the implementation of the Temporary Assistance to Needy Families Program: AFDC Unemployed/Underemployed Parent (UP) Requirements to allow the State to eliminate the 100 hour rule requirement for the primary wage earner in a two-parent household.

The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.

2.A.2 Pregnant Women

The Basic Benchmark Benefit Package is available for pregnant women and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A)(i)(IV) and 1902(l) (1)(A) and (B) of the Act.

The Basic Benchmark Benefit Package is available for pregnant women who are determined by a "qualified provider" (as defined in §1920(b)(2) of the Act) based on preliminary information, to meet the applicable income criteria and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with §1920 of the Act.

2.A.3 Low-Income Children

The Basic Benchmark Benefit Package is available for children who have attained 1 year of age but have not attained 6 years of age, with family incomes at or below 133 percent of the

Federal poverty levels.

The Basic Benchmark Benefit Package is available for children who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

The Basic Benchmark Benefit Package is available for a child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.

The Basic Benchmark Benefit Package is available for children who would not be eligible for Medicaid under the policies in the State's Medicaid Plan as in effect on April 15, 1997 (other than because of the age expansion provided for in section 1902 (1) (2) (D)) and have family income at or below 150 percent of the federal poverty level. Medical assistance for these children is provided under the State Children's Health Insurance Program authorized under Title XXI of the Social Security Act, implemented in October 1997 as expanded benefits under the State's Medicaid Plan.

2.B GENERAL CONDITIONS OF ELIGIBLITY

Each individual provided Medical Assistance under this State plan must meet the conditions of eligibility described in this section.

Each individual provided Medical Assistance under this State Plan must meet the applicable non-financial eligibility conditions.

2.D **APPLICATION PROCEDURES**

The Department meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medical Assistance.

The Department has procedures to take applications, assist applicants, and perform initial processing of applications for Medical Assistance that includes informing each eligible individual of available benefit options. The Department will inform each individual in a covered population that enrollment in the Basic Benchmark Benefit Package is voluntary (i.e. participants may opt-in), and that such individuals may opt-out

of the Basic Benchmark Benefit Package at any time and regain immediate eligibility for Medicaid benefits under the State plan.

The Department will provide such information, in writing, to covered populations, at the following opportunities:

- Initial application for assistance;
- Notice of eligibility determination; and
- Selection of primary care case manager.

To ensure that children are provided with the benefit package that will lead most directly to desired health outcomes, and to ensure that these benefits represent the most effective and efficient use of scarce health resources, Idaho Medicaid will incorporate a health risk assessment into Idaho's eligibility determination process and primary care case management (PCCM) program, Healthy Connections.

Applicants for medical assistance will complete an accompanying health questionnaire designed to assess general health status and health behaviors. The questionnaire will also serve as a screening tool to determine whether the applicant has special health needs. The Department will also assess whether the applicant requires special education services or is enrolled in Idaho's Children's Special Health Program, Infant and Toddler Program, Children's Mental Health Program or Adult Mental Health Program.

Eligibility for Idaho's Children's Mental Health Program requires a diagnosis of "serious emotional disturbance (SED). SED in children is defined in Idaho Code 16-2403(13), and further defined in Department rules. Eligibility for Idaho's Adult Mental Health Program requires a "serious and persistent mental illness" (SPMI). SPMI in adults is defined in Department rules.

Children with special health needs will be enrolled in the Enhanced Benchmark Benefit Package. Individuals without such needs will be enrolled in the Basic Benchmark Benefit Package. In addition, the questionnaire will determine whether the applicant is currently under treatment by a physician or has a medical home. If not, the applicant will receive information about Healthy Connections providers and will be asked to select a primary care provider as part of the eligibility determination process.

Failure to complete a health questionnaire will not prohibit an applicant from being determined eligible for medical assistance. However, without a completed health questionnaire, children cannot be immediately provided with

the Enhanced Benchmark Benefit Package.

Subsequent to selection of a Healthy Connections provider, the participant will visit a physician for a comprehensive exam and health education. This assessment will comply with federal requirements for EPSDT for children. If the health risk assessment indicates a previously unknown special health need, the participant will be provided with the Enhanced Benchmark Benefit Package. The health risk assessment process will therefore act as both a component of eligibility determination and a safeguard to ensure that benefits address beneficiary health needs by providing access to needed services available under the appropriate benefit package.

SECTION 3. COVERED SERVICES

3.A GENERAL PROVISIONS

Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, except for Nursing Facility in section 1905(a)(4)(A), is provided as defined in 42 CFR Part 440, Subpart A. For EPSDT services in section 1905(a)(4)(B), the provisions of section 1905(r) and 42 CFR Part 441, Subpart B are met by providing for Medical Assistance to any eligible child under the State plan through the most appropriate benefit options. If a child is eligible for services under EPSDT not covered in the Basic Benchmark Benefit Package, that child will be deemed to have a special health need and be permitted to receive services (without regard to amount, scope and duration limitations) under an Enhanced Benchmark Benefit Package.

3.B HOSPITAL SERVICES

3.B.1 Inpatient Services

The Basic Benchmark Benefit Package includes **Inpatient Hospital Services** permitted under sections 1905(a)(1) and 2110(a)(1) of the Social Security Act. These services include semi-private room, intensive and coronary care units, general nursing, drugs, oxygen, blood transfusions, laboratory, imaging service, physical, speech, occupational, heat and inhalation therapy; operating, recovery, birthing, and delivery rooms, routine and intensive care for newborns and other medically necessary benefits and prescribed supplies for treatment of injury or illness are covered.

No limitation is placed on the number of inpatient hospital days. However, such inpatient services must be Medically necessary as determined by the Department or its authorized agent.

Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment.

Inpatient hospital services do not include those services provided in an institution for mental diseases.

Inpatient services that are being furnished to infants and children described in section 1902(1)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Payment is limited to semi-private room accommodations unless private accommodations are medically necessary and ordered by the physician.

Excluded Services. The following services are excluded from the Basic Benchmark Benefit Package covered under the State plan.

Elective medical and surgical treatments, except family planning services and medically necessary cosmetic surgery, are excluded from Medicaid payment unless prior approved by the Department or its authorized agent. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and that are excluded by the Medicare program are excluded from Medicaid payment.

Acupuncture, bio-feedback therapy, and laetrile therapy are excluded from Medicaid payment.

Procedures, counseling, and testing for the inducement of fertility are excluded from Medicaid payment.

Surgical procedures for the treatment of morbid obesity and panniculectomies are excluded unless prior approved by the Department or its authorized agent.

3.B.2 **Outpatient Services**

The Basic Benchmark Benefit Package includes **Outpatient Hospital Services** permitted under sections 1905(a)(2) and 2110(a)(2) of the Social Security Act. These services include all benefits described in the inpatient hospital section which are provided on an outpatient basis in a hospital (including, but not limited to, observation beds and partial hospitalization benefits) or ambulatory surgical center; chemotherapy; emergency room benefits for surgery, injury or medical emergency; and other services for diagnostic or outpatient treatment of a medical condition, injury or illness are covered.

Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment.

Limitations. The following service limitations apply to The Basic Benchmark Benefit Package covered under the State plan.

Visits by physical therapists and occupational therapists are limited to a total of one hundred (100) visits per recipient per calendar year. Psychotherapy services are limited to forty-five (45) hours per calendar year. Psychological evaluation, speech and hearing evaluations, physical therapy evaluation occupational therapy evaluation, and diagnostic services are limited to twelve (12) hours for each eligible recipient per calendar year. Diabetic education and training services are limited to twenty-four (24) hours of group counseling and twelve (12) hours of individual counseling through a diabetic education program or by a certified diabetic educator recognized by the American Diabetes Association.

3.B.3 **Emergency Services**

The Basic Benchmark Benefit Package includes **Emergency Hospital Services** provided when necessary to prevent death or serious impairment of health and when conditions dictate use of the most accessible hospital available, even if the hospital does not currently meet the conditions for participation under Medicare or the definitions of inpatient or outpatient hospital services included elsewhere in this State plan. All obstetrical deliveries provided to aliens per Section 1903 (v) (3) of the Act

are designated as emergency services.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Emergency room services are limited to six (6) visits per calendar year. Those services, however, which are followed immediately by admission on an inpatient status will be excluded from the above limitation.

The limit of six (6) emergency room visits will be waived for EPSDT recipients.

3.C. AMBULATORY SURIGCAL CENTER SERVICES

The Basic Benchmark Benefit Package includes **Ambulatory Surgical Center Services** in addition to services covered as Inpatient and Outpatient Hospital and Physician benefits permitted under sections 1905(a)(9), and 2110(a)(4) of the Social Security Act, including services provided under section 1905(a)(9).

Ambulatory surgical center services are outlined in applicable Department rules and must be provided in a facility certified by Medicare as an ASC, and are restricted to those procedures identified by the Medicare program in accordance with 42 CFR 416.65, or identified by the Department as meeting such requirements.

3.D PHYSICIAN SERVICES

3.D.1 Medical Services

The Basic Benchmark Benefit Package includes **Physician Services** permitted under sections 1905(a)(5) and 2110(a)(4) of the Social Security Act. These services include office, clinic, outpatient surgery center and hospital treatment by a physician for a medical condition, injury or illness. Physician services are covered whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

The Basic Benchmark Benefit Package includes treatment of medical and surgical conditions by doctors of medicine or

osteopathy subject to the limitations of practice imposed by state law, and in accordance to the restrictions and exclusions of coverage contained in applicable Department rules. Medically appropriate second opinions are covered.

Limitations. Limits on psychiatric evaluations and psychotherapy in any twelve (12) month period for Outpatient Mental Health Services shall not apply when such services are provided as Physician Services.

3.D.2 Surgical Services

Surgical Services. The Basic Benchmark Benefit Package includes professional services rendered by a physician, surgeon or doctor of dental surgery.

Abortion Services. A legal abortion is only covered to save the life of the mother or in cases of rape or incest as determined by the courts.

When a pregnancy is life threatening and abortion is provided to save the life of the mother, one licensed physician or osteopath must certify in writing that the woman may die if the fetus is carried to term.

Cases of rape or incest must be determined by a court or documented by a report to law enforcement, except that if the rape or incest was not reported to law enforcement, a licensed physician or osteopath must certify in writing that, in his/her professional opinion, the woman was unable to report the rape or incest to law enforcement for reasons related to her health.

Excluded Services. The following services are excluded from the Basic Benchmark Benefit Package covered under the State plan.

Hysterectomies that are not medically necessary and sterilization procedures for people under twenty-one (21) are excluded from Medicaid payment.

3.E **OTHER PRACTITIONER SERVICES**

The Basic Benchmark Benefit Package includes **Other Practitioner Services** specified in sections 1905(a)(6) and 2110(a)(24) of the Social Security Act. These services include medical care and any other type of remedial care recognized

under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

Certified Pediatric or Family Nurse Practitioners' Services. Certified pediatric or family nurse practitioners' services are those services provided by certified pediatric or family nurse practitioners as defined by state and federal law**.** This coverage has the same exclusions as Physician Services. This coverage specifically includes services by certified pediatric and family nurse practitioners as required by Section 1905(a)(21) of the Act. Services provided by nurse practitioners are limited to Section 54-1402(d) of Idaho Code.

Physician Assistant Services. Physician assistant services include those services provided by a physician assistant as defined by state and federal law. This coverage has the same exclusions as Physician Services.

Services provided by physician assistants are limited to Section 54-1803(11) of the Idaho Code.

Chiropractor Services. Chiropractic services are limited for payment to a total of twenty-four (24) office visits during any calendar year. The remedial treatment must involve the manipulation of the spine to correct a subluxation condition.

Podiatrist Services. Podiatrist Services are limited to treatment of acute foot conditions.

Optometrist Services. Optometrist services are limited to providing eye examination and eyeglasses covered under this State Plan unless the optometrist has been issued and maintains certification under the provisions of Idaho Code to diagnose and treat injury or diseases of the eye. In these circumstances, payment will be made for diagnosis and treatment services.

Nurse-Midwife Services. Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

Certified nurse-midwife services are those services provided by certified nurse midwives as defined by state and federal law. This coverage has the same exclusions as Physician Services.

3.F PRIMARY CARE CASE MANAGEMENT

The Basic Benchmark Benefit Package includes **Primary Care Case Management Services** permitted under in sections 1905(a)(25) and 2110(a)(21) of the Social Security Act. These services are provided by a primary care case manager consistent with a waiver program authorized under section 1915(b) of the Social Security Act.

3.G PREVENTION SERVICES

The Basic Benchmark Benefit Package includes **Prevention Services** permitted under sections 1905(a)(3), 1905(a)(5), 1905(a)(6), 1905(a)(9), 1905(a)(13), 1905(a)(28), 2110(a)(3), 2110(a)(5), 2100(a)(8), 2100(a)(24) and 2110(a)(28) of the Social Security Act.

Health Risk Assessments. The Basic Benchmark Benefit Package includes a Health Risk Assessment which consists of:

- An initial health questionnaire, and
- A well child screen, or
- An adult physical.

The health questionnaire is designed to assess the general health status and health behaviors of a recipient. This information will be used to provide customized health education. The health questionnaire will be administered at initial program entry and periodic intervals thereafter.

A well child screen or adult physical conducted at periodic or interperiodic intervals which constitutes a health risk assessment will consist of a comprehensive physical examination and health education.

3.G.1 **Well Child Screens.**

The Basic Benchmark Benefit Package includes periodic medical screens completed at intervals recommended by the AAP, Committee in Practice and Ambulatory Medicine. Physicians and physician extenders will be required to bill using the appropriate Physician's Current Procedural Terminology (CPT) codes, under section "Preventive Medicine Services".

EPSDT RN screeners will be required to bill using codes established by the Department, except when the EPSDT RN screener is an employee of a rural health clinic, Indian Health Clinic, or federally qualified health clinic.

One screen at initial program entry, up to the recipient's twenty-first birthday. The initial screen at program entry should constitute a health risk assessment as specified in applicable Department rules.

One (1) screen at or by age:

- one (1) month,
- two (2) months,
- three (3) months,
- four (4) months,
- six (6) months, and
- nine (9) months.

One (1) screen at or by age:

- twelve (12) months,
- fifteen (15) months,
- eighteen (18) months, and
- twenty-four (24) months.

One (1) screen at or by age:

- three (3) years,
- four (4) years, and
- five (5) years.

One (1) screen at or by age:

- six (6) years,
- eight (8) years,
- ten (10) years,
- twelve (12) years, and
- fourteen (14) years.

One screen at or by age:

- sixteen (16) years,
- eighteen (18) years, and
- twenty (20) years.

Periodic screens and Interperiodic screens should constitute a health risk assessment as specified in applicable Department rules. Interperiodic medical screens are screens that are done at intervals other than those identified in the basic medical periodicity schedule above, and must be performed by physician or physician extender. Interperiodic screens will be required to be billed using the correct Physician's Current Procedural Terminology (CPT) under section "Evaluation and Management". Interperiodic screens will be performed when

there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. Interperiodic screening examinations may occur in children who have already been diagnosed with an illness or condition, and there is indication that the illness or condition may have become more severe or changed sufficiently, so that the further examination is medically necessary.

Developmental screening is considered part of every routine initial and periodic examination. If the screening identifies a developmental problem then a developmental assessment will be ordered by the physician and conducted by qualified professionals. EPSDT RN screeners will routinely refer all clients to primary care providers. EPSDT clients ages two (2) weeks to two (2) years shall receive at least one (1) of their periodic or inter-periodic screens annually from a physician or physician extender unless otherwise medically indicated. A parent or guardian may choose to waive this requirement. EPSDT RN screeners will refer clients for further evaluation, diagnosis and treatment to appropriate services (e.g. physician, registered dietitian, developmental evaluation, speech, hearing and vision evaluation, blood lead level evaluation). Efforts shall be made to assume that routine screening will not be duplicated for children receiving routine medical care by a physician.

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EPSDT Registered Nurse Screener. A licensed professional nurse (RN) who is currently licensed to practice in Idaho, and who meets the following provisions:

- Has completed a Child Assessment training course (or equivalent as approved by the Department) that prepares the RN to identify the difference between screening, diagnosis, and treatment; and prepares the RN to appropriately screen and differentiate between normal and abnormal findings. Training must include at least five (5) days didactic instruction in child health assessment, accompanied by a component of supervised clinical practice; and

- Is employed by a physician, district health department, rural health clinic, Indian Health Clinic, or federally qualified health clinic in order to provide linkage to primary care services. The employers must have a signed Medical Provider Agreement and possess an active Provider Number; or

- Has established and maintains an agreement with a physician or nurse practitioner for consultation on an

as-needed basis.

3.G.3 Adult Physicals

The Basic Benchmark Benefit Package includes an annual preventive health visit consisting of procedures recommended by the US Prevention Services Task Force Guide to Clinical Preventive Services. Physicians and physician extenders will be required to bill using the appropriate Physician's Current Procedural Terminology (CPT) codes, under section "Preventive Medicine Services".

3.G.4 Screening Services

Mammography Services. The Basic Benchmark Benefit Package screening mammographies performed with certified mammography equipment and staff. Screening mammographies will be limited to one (1) per calendar year for women who are forty (40) or more years of age.

Diagnostic Screening Clinics. The Basic Benchmark Benefit Package includes services provided in a diagnostic screening clinic are outlined in applicable Department rules.

Limitations. Service limitations are as follows: five (5) hours of medical social services per eligible recipient per state fiscal year is the maximum allowable. Limit of no more than five (5) hours of medical social services per recipient in each state fiscal year will be waived for EPSDT recipients.

3.G.5 Prevention and Health Assistance Benefits

The Basic Benchmark Benefit Package includes certain enhanced Prevention and Health Assistance (PHA) benefits for targeted individuals provided in accordance with applicable Department rules.

Enhanced PHA Benefits are individualized benefits to address targeted health behaviors. Authorizations will be managed by the State Medicaid agency.

PHA benefits made available under the Basic Benchmark Benefit Package will be targeted to individuals who:

- Use tobacco, or
- Are obese.

PHA benefits will be available when individuals complete specified activities in preparation for addressing the targeted

health condition. These activities include discussing the condition with their primary care provider, participating in an applicable support group, and completing basic educational material related to the condition.

PHA benefits may be used to purchase goods and services related to tobacco cessation and weight reduction/management in accordance with applicable Department rules. These goods and services may include nicotine patches or gum, weight-loss programs, dietary supplements, and other health related benefits.

3.G.6 **Nutrition Services**

The Basic Benchmark Benefit Package includes intensive nutritional education, counseling, and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/professional requirements in dietetics as approved by the American Dietetics Association to assure the patient's proper nutrition is allowed. Payment is made at a rate established in accordance with applicable Department rules. Nutrition services must be discovered by the screening services and ordered by the physician; must be medically necessary; and, if over two (2) visits per year are needed, must be authorized by the Department prior to the delivery of additional visits.

Limitations. Nutrition services related to obesity, including dietary assessment and individualized nutrition education, shall not be subject to the above limitations when provided as PHA benefits.

Nutrition services in the Basic Benchmark Benefit Package include Diabetes Education and Training Clinics which provide diabetic education and training services outlined in applicable Department rules. Outpatient diabetes education and training services will be covered under the following conditions.

The education and training services are provided through a diabetic management program recognized as meeting the program standards of the American Diabetes Association.

The education and training services are provided through a formal program conducted through a hospital outpatient department or a physician's office by a Certified Diabetic Educator certified by the American Diabetes Association.

Only training and education services which are reasonable and necessary for treatment of a current injury or illness will be covered. Covered professional and educational services will address each client's medical needs through scheduled outpatient group or individual training or counseling concerning diet and nutrition, medications, home glucose monitoring, insulin administration, foot care, or the effects of other current illnesses and complications.

To receive diabetic counseling, the following conditions apply to each patient:

- the patient must have a written order by his or her primary care physician or physician extender referring the patient to the program; and
- the physician may not use the formally structured program or a Certified Diabetes Educator as a substitute for basic diabetic care and instruction that the physician must furnish to the patient which includes the disease process/pathophysiology of diabetes mellitus and dosage administration of oral hypoglycemic agents.

The medical necessity for diabetic education and training are evidenced by the following:

- a recent diagnosis of diabetes within ninety (90) days of enrollment with no history of prior diabetic education; or,
- uncontrolled diabetes manifested by two or more fasting blood sugar of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin greater than eight percent (8%), or random blood sugar greater than one hundred eighty milligrams per decaliter (180 mg/dL), in addition to manifestations, or
- recent manifestations resulting from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or non-healing wounds.
- Diabetes education and training services will be limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years.

Limitations. Diabetes education related to obesity shall not be subject to the above limitations when provided as PHA benefits.

3.H **LABORATORY AND RADIOLOGICAL SERVICES**

The Basic Benchmark Benefit Package includes **Laboratory and Radiological Services** permitted under sections 1905(a)(3) and 2110(a)(8) of the Social Security Act. These services include imaging and laboratory services for diagnostic and therapeutic purposes due to accident, illness or medical condition, as well as X-ray, radium or radioactive isotope therapy.

Laboratory and x-ray services are provided upon and under the direction of a physician or other licensed practitioner.

Excluded Services. The following services are excluded from the Basic Benchmark Benefit Package covered under the State plan.

Laboratory and/or x-ray procedures which are associated with excluded Hospital Services and Physician Services are excluded from payment.

3.I **PRESCRIBED DRUGS**

The Basic Benchmark Benefit Package includes **Prescribed Drugs** permitted under sections 1905(a)(12), 2110(6) and 2110(a)(7) of the Social Security Act. These services include drugs prescribed by a practitioner acting within the scope of his practice, chemotherapy drugs approved for use in humans by the U.S. Food and Drug Administration, vaccines and prenatal vitamins.

Prescribed drugs are provided for non-institutionalized persons as well as institutionalized patients. Prescriptions for oral contraceptives and diaphragms for women of child bearing age are also eligible for payment. All drug products requiring, by state or federal law, a licensed practitioner's order for dispensing or administration which are medically necessary are purchasable except for (1) those specifically excluded as ineffective or inappropriate by the Department of Health and Welfare policy, or (2) those drugs not eligible for federal participation. A prescription drug is considered medically necessary for a client if it is reasonably calculated to prevent or treat conditions in the client that endanger life, cause pain or functionally significant deformity or malfunction; and there is no other therapeutically interchangeable prescription drug available or suitable for the client requesting the service which is more conservative or substantially less costly; and the prescription drug meets professionally recognized standards of health care and is substantiated by prescriber's records

including evidence of such medical necessity. Those records shall be made available to the Department upon request. The criteria used to determine medical necessity is stated in applicable Department rules.

Additional Covered Drug Products. Additional drug products will be covered as follows:

- Therapeutic Vitamins;
- Injectable Vitamin B12 (cyanocobalamin and analogues);
- Vitamin K and analogues;
- Pediatric vitamin-fluoride preparations;
- Legend prenatal vitamins for pregnant or lactating women;
- Legend folic acid;
- Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and
- Legend Vitamin D and analogues.

Prescriptions for non-legend products will be covered as follows:

- Insulin;
- Disposable insulin syringes and needles;
- Oral iron salts; and
- Permethrin; and
- Federal legend medications that change to non-legend status, as well as their therapeutic equivalents, based on Director approval which is determined by appropriate criteria including safety, effectiveness,

clinical outcomes, and the recommendation of the P&T committee.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan. Prior authorization will be required for certain drugs and classes of drugs. The Department utilizes the Idaho State University School of Pharmacy for literature, research, and the state Drug Utilization Review (DUR) Board, and Medicaid's Medical Director and staff pharmacists within the Division of Medicaid, as the Prior Authorization committee. Criteria used to place drugs on prior authorization is based upon safety, efficacy and clinical outcomes as provided by the product labeling of the drug. Prescribing physicians, pharmacists, and/or designated representatives may contact the Medicaid Pharmacy Unit for prior authorizations via 1-800 phone and fax lines, or by mail. Responses are issued within 24 hours of the request. Pharmacies are authorized to dispense a 72 hour supply of a prior authorized product in the event of an emergency. The program complies with requirements set forth in section 1927 (d) (5) of the Social Security Act pertaining to prior authorization programs. The following drugs require prior authorization:

- Amphetamines and related CNS stimulants;
- Growth hormones;
- Retinoids;
- Brand name drugs when acceptable generic form is available;
- Medications otherwise covered by the Department for which there is a less costly, therapeutically interchangeable medication covered by the Department;
- Medications prescribed in quantities which exceed the Food and Drug Administration (FDA) dosage guidelines;
- Medications prescribed outside of the FDA approved indications;
- Lipase inhibitors; and
- FDA, 1-A rated single source and innovator multi-source drugs manufactured by companies not participating in the National Rebate Agreement, which have been

determined by the Department to be medically necessary.

Non-covered Drugs must be discovered as being medically necessary by the screening services for individuals under twenty-one (21) years of age qualifying under EPSDT; and must be ordered by the physician and must be authorized by the Department or its authorized agent prior to purchase of the drug.

Limitation of Quantities. The Basic Benchmark Benefit Package has a limitation that no more than a thirty-four (34) day supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription. To provide enhanced control over this limitation, the Point of Sale (POS) system has added an early refill edit to identify medication refills provided before at least seventy five percent of the estimated days supply has been utilized. This edit can be overridden by the pharmacy if a change in dosage is ordered. The edit is designed to prevent waste and abuse by preventing unnecessary refills, and identify clients who may be accessing multiple physicians and pharmacies and stockpiling medications. The following medications are the only exceptions to the 34 day supply limitation.

Up to one hundred (100) unit doses or a 100 day supply, whichever is less, of the following medications may be purchased:

- Cardiac glycosides;
- Thyroid replacement hormones;
- Prenatal vitamins;
- Nitroglycerin sublingual and dermal patch products;
- Fluoride and vitamin fluoride combination products; and
- Nonlegend oral iron salts.

Oral contraceptive products may be purchased in a quantity sufficient for one (I), two (2), or three (3) cycles.

Excluded Drug Products. The following categories and specific

products are excluded:

- Legend drugs for which Federal Financial Participation is not available
- Nonprescription items (without the Federal Legend), except permethrin, oral iron salts, disposable insulin syringes and needles.
- Ovulation stimulants and fertility enhancing drugs.
- Medications used for cosmetic purposes.
- Prescription vitamins except injectable B12, vitamin K, legend vitamin D, legend pediatric vitamin and fluoride preparations, legend prenatal vitamins for pregnant or lactating women, and legend folic acid.

Nicotine cessation products, diet supplements and weight loss products are excluded unless provided as PHA benefits.

3.J **FAMILY PLANNING SERVICES**

The Basic Benchmark Benefit Package includes **Family Planning Services** permitted under sections 1905(a)(4)(C) and 2110(a)(9) of the Social Security Act. These services include pre-pregnancy family planning services and prescribed supplies are covered including birth control contraceptives.

Family planning services and supplies for individuals of child-bearing age include counseling and medical services prescribed by a licensed physician, qualified certified nurse practitioner, or physician's assistant. The Basic Benchmark Benefit Package covers diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization.

The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

All requirements of 42 CFR Part 441, Subpart F are met.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives, which are limited to purchase of a three-month supply.

Sterilization procedures are limited to persons who are at least twenty-one (21) years of age or older at the time of signing the informed consent form. A person over the age of 21 that is incapable of giving informed consent will be ineligible to receive Medicaid payment for the sterilization. The person must voluntarily sign the informed consent form at least thirty (30) days, but not more than 180 days, prior to the sterilization procedure. Sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are ineligible unless ordered by the court of law. Hysterectomies performed solely for sterilization are ineligible for Medicaid payment.

3.K MENTAL HEALTH SERVICES

3.K.1 Inpatient Psychiatric Services

In addition to Psychiatric Services covered under Inpatient Hospital Services, the Basic Benchmark Benefit Package Medical Assistance includes services **for Certain Individuals in Institutions for Mental Diseases** permitted under sections 1905(a)(14) of the Social Security Act.

Inpatient psychiatric facility services for individuals under 22 years of age include services provided which meet medical necessity criteria determined by the Department or its authorized agent and provided in a JCAHO accredited hospital.

Limitations. Inpatient mental health services, including Psychiatric Services covered under Inpatient Hospital Services, are limited to ten (10) days per calendar year.

3.K.2 Outpatient Mental Health Services

In addition to Mental Health Services covered under Outpatient Hospital Services, the Basic Benchmark Benefit Package includes **Clinic Services** and other Rehabilitative Services permitted under sections 1905(a)(9), 2110(a)(5), 1905(a)(13) and 2110(a)(11) of the Social Security Act.

Mental Health Clinics. Clinic services are preventative, diagnostic, therapeutic, rehabilitative, or palliative items or

services furnished to an outpatient by or under the direction of a physician. Services provided in a mental health clinic are outlined in applicable Department rules.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Psychotherapy Services. As set forth in applicable Department rules are limited to twenty-six (26) visits per calendar year.

Evaluation and Diagnostic Services. Any combination of any evaluative or diagnostic services and care plan development is included in the limit of twenty-six (26) visits per calendar year.

Excluded Services. The following services are excluded from the Basic Benchmark Benefit Package covered under the State Plan.

- Partial care treatment, and
- Psychosocial rehabilitation.

3.L HOME HEALTH CARE

The Basic Benchmark Benefit Package includes **Home Health Care Services** permitted under sections 1905(a)(7), 1905(a)(8), 2110(a)(14) and 2110(a)(15) of the Social Security Act.

The Basic Benchmark Benefit Package includes **Home Health Services** permitted under sections 1905(a)(7), 2110(a)(14) and 2110(a)(15) of the Social Security Act.

These services include intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Services also include home health aide services provided by a home health agency.

Home health services are provided in accordance with the requirements of 42 CFR 441.15.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Services by a licensed nurse, when no home health agency exists in the area, must be prior approved by the Department as defined in 42 CFR 440.70(b)(l).

Home health visits are limited to one hundred (100) per recipient per calendar year provided by any combination of home health agency licensed nurse, home health aide, home health physical therapist, home health occupational therapist, or licensed nurse.

Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive in excess of one-hundred (100) visits per calendar year limit.

3.M THERAPY SERVICES

The Basic Benchmark Benefit Package includes **Therapy Services** permitted under sections 1905(a)(11), 1905(a)(13) and 2110(a)(22) of the Social Security Act. These services include physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Physical therapy services may be furnished by a licensed physical therapist as defined under 42 CFR 440.110 by direct order of a physician as a part of a plan of care, and be provided either in the patient's home or in the therapist's office. An office in a nursing home or hospital is not considered an independent therapist's office.

Respiratory care services may be furnished to Individuals under twenty-one (21) years of age qualifying under EPSDT.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Recipients are limited to twenty-five (25) visits per calendar year without prior authorization by the Department. Included in this limitation are outpatient hospital, independent

providers, and physical therapy under school-based services and developmental disability agencies.

Home health agency visits by physical therapists and occupational therapists are limited to a total of one-hundred (100) visits per recipient per calendar year. Included in the total visit are all home health aides, nursing services, physical therapy services, and occupational therapy services in any combination. Speech pathology and audiology services are not provided for under home health services.

3.N SPEECH, HEARING AND LANGUAGE SERVICES

The Basic Benchmark Benefit Package includes **Speech, Hearing and Language Services** permitted under sections 1905(a)(6) and 2110(a)(24) of the Social Security Act. These services include services for individuals with speech, hearing, and language disorders provided by or under the supervision of a speech pathologist or audiologist.

Audiology Services include audiometric services and supplies according to applicable Department rules. The Department will provide hearing screening services according to the recommended guidelines of the AAP. The screen administered will be an age-appropriate hearing screen. The guidelines coincide with certain scheduled medical screens; the hearing screen is considered part of the medical screening service.

Hearing Aids. Hearing aids and related services will be covered by the Department.

Augmentative Communication Devices. Augmentative communication devices are covered as specified in applicable Department rules.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

The Department will pay for one audiometric examination and testing related to the exam each calendar year when ordered by a physician and provided by a certified audiologist and/or licensed physician. Any hearing test beyond the basic comprehensive audiometry and independent testing must be ordered in writing before the testing is done.

The Department will purchase one (1) hearing aid per recipient with prior approval of the Department. Follow up services are

included in the purchase of the hearing aid for the first year. Necessary repairs resulting from normal use after the second year will be covered. Hearing aid batteries will be purchased on a monthly basis. Refitting of hearing aid or additional ear molds will be purchased no more often than forty-eight (48) months from the last fitting.

Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive audiology services and supplies ordered by a licensed physician and supplied by a physician or certified audiologist, with the following exceptions:

- When binaural aids are requested they will be authorized if documented to the Department's satisfaction, that the child's ability to learn would be severely restricted; or
- Replacement hearing aids may be authorized if the requirements in applicable Department rules are met.

The Department will purchase additional ear molds after the initial six (6) months to one (1) year period if medically necessary. Requests in excess of every six (6) months will require prior authorization and documentation of medical need from either the attending physician or audiologist.

3.O MEDICAL EQUIPMENT, SUPPLIES AND DEVICES

3.O.1 **Medical Equipment and Supplies**

The Basic Benchmark Benefit Package includes **Medical Equipment and Supplies** permitted under sections 1905(a)(28), 2110(a)(12) and 2110(a)(13) of the Social Security Act. These services include durable medical equipment and other medically-related or remedial devices. These also include medical supplies, equipment, and appliances suitable for use in the home.

Medical equipment and medical supplies must be ordered in writing by a physician. Medical equipment and supplies are provided only on a written order from a physician that includes the medical necessity documentation listed in the Medicare DMERC Supplier manual.

The Department requires recipients to obtain certain services only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

The State assures it will comply with 42 CFR 431.55(f) as it relates to this fee-for-service selective contracting system.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State Plan.

Items not specifically listed in applicable Department rules will require prior authorization by the Department or its authorized agent.

3.O.2 **Specialized Medical Equipment and Supplies**

The Basic Benchmark Benefit Package includes **Specialized Medical Equipment and Supplies** permitted under sections 1905(a)(4)(B) or 1915(c)(4)(B) of the Social Security Act.

Oxygen and related equipment is covered for Individuals under twenty-one (21) years of age qualifying under EPSDT, when the medical need is discovered during a screening service and is physician ordered. PRN oxygen, or oxygen as needed on less than a continual basis, will be authorized for six (6) months following receipt if medical documentation from the attending physician as to an acute or chronic medical condition which requires oxygen support to maintain respiratory status. Medical documentation will include a diagnosis, oxygen flow rate and concentration, and an estimate of the frequency and duration of use. Portable oxygen systems may be ordered to compliment a stationary system if the recipient is respirator dependent, or the attending physician documents the need for a portable oxygen system for use in transportation. Laboratory evidence for hypoxemia is not required under the age of six (6) months.

3.O.3 **Prosthetic Devices**

The Basic Benchmark Benefit Package includes **Prosthetic Devices** permitted under sections 1905(a)(6), 1905(a)(12) and 2110(a)(24) of the Social Security Act. These services include prosthetic and orthotic devices and related services prescribed by a physician and fitted by an individual who is certified or registered by the American Board for Certification in orthotics and/or prosthetics.

The Department will purchase and/or repair medically necessary prosthetic and orthotic devices and related services which artificially replace a missing portion of the body or support a weak or deformed portion of the body.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Att 3.1A-PD 12c

Prosthetic and orthotic devices and services will be purchased only if pre-authorized by the Department or its authorized agent. Limit of one refitting, repair or additional parts in a calendar year.

Att 3.1A-PD 4b(xvii)(h)

Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive more than one refitting, repair or additional parts in a calendar year.

3.P **VISION SERVICES**

The Basic Benchmark Benefit Package includes **Vision Services** permitted under sections 1905(a)(6), 1905(a)(12) and 2110(a)(24) of the Social Security Act. These services include eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

The Department will pay for vision services and supplies. One eye exam by physicians and/or optometrists is allowed during any twelve (12) month period. The Department will provide vision-screening services according to the recommended guidelines of the AAP. The screen administered will be an age-appropriate vision screen. The guidelines coincide with certain scheduled medical screens; the vision is considered part of the medical screening service, (i.e. eye chart). The Department will pay for one (1) eye examination by an ophthalmologist or optometrist during any twelve (12) month period for each eligible recipient to determine the need for glasses to correct or treat refractive error.

Eyeglasses. Each recipient, following a diagnosis of visual defects and a recommendation that eyeglasses are needed for correction of a refractive error, can receive one (1) pair of eyeglasses per year, except in the following circumstances: In the case of a major visual change, the Department can authorize purchase of a second pair of eyeglasses and can authorize a second eye examination to determine that visual change; or the Department may pay for replacement of lost glasses or replacement of broken frames or lenses. New frames will not be purchased if the broken frame can be repaired for less than the cost of new frames if the provider indicates one of these reasons on his claim. If repair costs are greater than the cost of new frames, new frames may be authorized.

Lenses will be provided when there is documentation that the correction needed is equal to or greater than plus or minus one-half (.50) diopters of correction.

The Department requires recipients to obtain eyeglasses only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

The State assures it will comply with 42 CFR 431.55(f) as it relates to this fee-for-service selective contracting system.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Polycarbonate lenses will be purchased only when it is documented that the prescription is above plus or minus two (2.00) diopters of correction. Payment for tinted lenses will only be made when there is a diagnosis of albinism or in the case of extreme medical conditions as determined by the Department. Contact lenses will be covered only when documentation of an extreme myopic condition requiring a correction equal or greater than minus four (-4) diopters, cataract surgery, keratoconus, or other extreme medical condition preclude the use of conventional lenses. Replacement lenses will be purchased only when there is documentation of a major visual change of at least one-half (.50) diopter plus or minus. One (1) set of frames will be purchased by the Department not more often than once every four (4) years for individuals over the age of twenty-one (21), except when documented by the physician and/or optometrist that there has been a major change in visual acuity that cannot be accommodated in the existing frames. Broken, lost, or missing glasses will not be repaired or replaced by the Department for individuals over the age of twenty-one (21).

3.Q DENTAL SERVICES

3.Q.1 Medical and Surgical Services

The Basic Benchmark Benefit Package includes **Medical and Surgical Services** furnished by a dentist permitted under sections 1905(a)(5)(B), 1905(a)(6) and 2110(a)(17) of the Social Security Act (in accordance with section 1905(a)(5)(B) of the Act) are covered for treatment of medical and surgical dental conditions when furnished by a licensed dentist subject to the

limitations of practice imposed by state law, and according to applicable Department rules.

Dentures are covered as specified in applicable Department rules.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Elective medical and surgical dental services are excluded from payment unless prior approved by the Department or its authorized agent. All hospitalizations for dental care must be prior approved by the Department or its authorized agent.

Excluded Services. The following services are excluded from the Basic Benchmark Benefit Package covered under the State plan.

Non-medically necessary cosmetic services are excluded from payment. Drugs supplied to patients for self-administration other than those allowed by applicable Department rules are excluded from payment.

3.Q.2 Other Dental Care

The Basic Benchmark Benefit Package includes **Other Dental Care** permitted under sections 1905(a)(5)(B), 1905(a)(6) and 2110(a)(17) of the Social Security Act. These services include professional dental services that are provided by a licensed dentist or denturist as described in applicable Department rules. Specific services covered for children are stated in applicable Department rules.

The Department will provide dental services for children through the month of their twenty-first (21st) birthday including diagnostic, preventative, restorative treatment, endodontics, periodontics, fixed and removable prosthodontics, maxillofacial prosthetics, oral surgery, orthodontics and adjunctive general services.

The Department required recipients to obtain certain services only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

3.R ESSENTIAL PROVIDERS

The Basic Benchmark Benefit Package includes **Clinic Services and Rehabilitative Services** furnished by certain essential providers permitted under sections 1905(a)(9), 1905(a)(13) and 2110(a)(5) of the Social Security Act.

Services from essential providers are preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician and which may include those services provided by community health centers.

3.R.1 Rural Health Clinic Services

Rural Health Clinic services and other ambulatory services furnished by a rural health clinic, which are otherwise included in the State plan.

3.R.2 Federally Qualified Health Center Services

Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the State plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Federally qualified health centers are provided within the scope, amount, and duration of the State's Medical Assistance Program as described under applicable Department rules.

3.R.3 Indian Health Services Facility Services

Indian Health Service Facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

3.R.4 Independent Schools District Services

Independent School Districts which have entered into a provider agreement with the Department provide rehabilitative services which are the core medical rehabilitative services to be provided on a statewide basis. Services provided by Independent School Districts are outlined in the applicable Department rules.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State

plan.

Evaluation and diagnostic services are limited to twelve (12) hours in any calendar year.

Psychotherapy services are limited to a maximum of forty-five (45) hours per calendar year.

Speech and hearing services are limited to two hundred and fifty (250) treatment sessions per calendar year.

Physical therapy services are limited to one hundred (100) treatment sessions per calendar year.

Developmental and occupational therapy services are limited to thirty (30) hours per week.

Excluded Services. The following services are excluded from the Basic Benchmark Benefit Package covered under the State plan.

Vocational services are excluded.

Educational services are excluded.

Recreational services are excluded.

3.S MEDICAL TRANSPORTATION SERVICES

The Basic Benchmark Benefit Package includes **Medical Transportation Services** permitted under sections 1905(a)(26), 1905(a)(6) and 2110(a)(17) of the Social Security Act.

These services include transportation services and assistance for eligible persons to medical facilities.

Payment for meals and lodging may be authorized where appropriate. Ambulance services will be covered in emergency situations or when prior authorized by the Department or its designee.

The Department operates a Brokered Transportation system. The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon the request of CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(f).

The Department will operate the broker system without regard to the statewideness requirements of section 1902(a)(1) of the Social Security Act. The broker system is operated only in Region 5, Region 6, and Region 7.

The Department will operate the broker system without regard to the freedom of choice requirements of section 1902(a)(23) of the Social Security Act. Recipients are required to use transportation providers with established agreements under the broker system.

Transportation services under the broker system will include:

- Wheelchair van;
- Taxi;
- Stretcher care;
- Bus passes;
- Tickets;
- Secured transportation; and
- Such other non-emergency transportation covered under the State plan.

The Department will assure the provision of necessary transportation of eligible persons to and from providers of Medicaid services.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Requests for transportation services will be reviewed and authorized by the Department or its designee. Authorization is required prior to the use of transportation services except when the service is emergency in nature. Payment for transportation services will be made, for the least expensive mode available, which is most appropriate to the recipient's medical needs.

Excluded Services. Transportation to medical facilities for the performance of medical services or procedures which are excluded under the Basic Benchmark Benefit Package are excluded.

3.U **SPECIAL SERVICES FOR CHILDREN/EPSDT**

EPSDT Services. The Department meets the requirements of sections 1902(a)(43),1905(a)(4)(B), and 1905(r) of the Social Security Act with respect to early and periodic screening, and diagnostic, and treatment (EPSDT) services.

The Basic Benchmark Benefit Package includes early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

Services under EPSDT are available to recipients up to and including the month of their twenty-first (21st) birthday.

EPSDT services include diagnosis and treatment involving medical care within the scope of Medical Assistance, as well as such other necessary health care described in Section 1905(a) of the Social Security Act, and not included in this State Plan as required to correct or ameliorate defects and physical and mental illness discovered by the screening service. The Department will set amount, duration and scope for services provided under EPSDT. Needs for services discovered during an EPSDT screening which are outside the coverage provided by applicable Department rules must be shown to be medically necessary and the least costly means of meeting the recipient's medical needs to correct or improve the physical or mental illness discovered by the screening and ordered by the physician, nurse practitioner or physician's assistant. The Department will not cover services for cosmetic, convenience or comfort reasons. Any service requested which is covered under Title XIX of the Social Security Act that is not identified in applicable Department rules specifically as a covered benefit or service will require preauthorization for medical necessity prior to payment for that service. Any service required as a result of an EPSDT screen and which is currently covered under the scope of the Basic Benchmark Benefit Package will be provided to individuals under the State plan without regard to amount, scope, and duration limitations, but will be subject to prior-authorization. The additional service must be documented by the attending physician as medically necessary and that the service requested is the least costly means of meeting the recipient's medical needs. Preauthorization from the Department or its authorized agent will be required prior

to payment. Those services required as a result of an EPSDT screen and which are currently covered under the scope of the Basic Benchmark Benefit Package will provided under an Enhanced Benchmark Benefit Package, or as wrap-around services to benefits covered under the State plan for children who do not opt-in to an Enhanced Benchmark Benefit Package.

The Basic Benchmark Benefit Package includes **Case Management Services** permitted under sections 1905(a)(19) and 2110(a)(20) of the Social Security Act.

Case Management (CM) services will be provided for the following target group(s) as permitted in accordance with section 1905(a)(19) or section 1915(g) of the Act.

Children Requiring Case Management Service under EPSDT.

Case Management Services for children under EPSDT require prior authorization and a Service Plan completed by the Department or its authorized agent for the initial Service Plan prior to delivery of case management services. The case manager must review and update the approved service plan for service coordination at least annually. The Department or its authorized agent must approve the Service Plan for continued prior authorization.

The Department requires recipients to obtain case management services only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

The State assures it will comply with 42 CFR 431.55(f) as it relates to this fee-for-service selective contracting system.

3.V **SPECIFIC PREGNANCY-RELATED SERVICES**

The Basic Benchmark Benefit Package **Pregnancy-related services**, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

Pregnancy-related and postpartum services are provided for a 60-day period after the pregnancy ends and any remaining days

in the month in which the 60th day falls.

The State provides the full range of Medicaid Program services with limitations as elsewhere described in this State plan to eligible pregnant women if such service is related to a medical condition identified by the Department or its authorized agent as pregnancy related (either routine postpartum care, or arising from complications of pregnancy, including delivery).

For presumptively eligible pregnant women, ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under this State plan.

Ambulatory prenatal care for pregnant women is furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

During the presumptive eligibility period, outpatient services related to pregnancy and complications are covered services to pregnant women. Limitations as described elsewhere in this State plan are applicable.

Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a) (10) (A) (i) (IV) and 1902(a) (10) (A) (ii) (IX) of the Act.

Special services related to pregnancy. When ordered by the patient's attending physician, nurse practitioner or nurse midwife, payment of the following services is available after confirmation of pregnancy and extending through the end of the month in which the 60th day following delivery occurs.

Risk Reduction Follow-up. Services to assist the client in obtaining medical, educational, social and other services necessary to assure a positive pregnancy outcome. Payment is available to licensed social workers, registered nurses and physician extenders either in independent practice or as employees of entities which have current provider agreements with the Department. A single payment for each month of service provided is made.

Individual and Family Medical Social Services. Services directed at helping a patient to overcome social or behavioral

problems which may adversely affect the outcome. Payment is available for two (2) visits during the covered period to a licensed social worker qualified to provide individual counseling according to the provisions of the Idaho Code and the regulations of the Board of Social Work Examiners.

Nutrition Services. Intensive nutritional education, counseling and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/profession requirements in dietetics as approved by the American Dietetic Association to assure the patient's proper nutrition. Payment for two (2) visits during the covered period is available.

Nursing Services. Home visits by a registered nurse to assess the client's living situation and provide appropriate education and referral during the covered period. A maximum of two (2) visits in the covered period is provided.

Maternity Nursing Visit. Office visits by a registered nurse, acting within the limits of the Nurses Practices Act, for the purpose of checking the progress of the pregnancy. These services must be prior authorized by the Department's care coordinator and can be paid only for women unable to obtain a physician to provide prenatal care. This service is to end immediately when a primary physician is found. A maximum of nine (9) visits can be authorized.

Qualified Provider Risk Assessment and Plan of Care. When prior authorized by the Department care coordinator, payment is made for qualified provider services in completion of a standard risk assessment and plan of care for women unable to obtain a primary care physician, nurse practitioner, or nurse midwife for the provision of antepartum care.

The Basic Benchmark Benefit Package includes **Case Management Services** permitted under sections 1905(a)(19) and 2110(a)(20) of the Social Security Act.

Case Management (CM) services will be provided for the following target group(s) as permitted in accordance with section 1905(a)(19) or section 1915(g) of the Act.

Pregnant and Parenting Teens and their Infants.

Eligible pregnant teens seventeen (17) years of age or younger at the time of conception. Teens who qualify for case

management at intake continue to qualify for case management services until the infant is one (1) year of age, so long as the goals of the case management plan have not been met. For purposes of this section, a teen is considered pregnant until 72 hours after delivery. Additionally, any Medicaid eligible teen/infant receiving targeted case management services since October 1, 1993, will be considered part of the target group. Teens and infants must live in Adams, Washington, Payette, Gem, Canyon, or Owyhee counties.

The Department requires recipients to obtain case management services only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

The State assures it will comply with 42 CFR 431.55(f) as it relates to this fee-for-service selective contracting system.